Respite Care

Definition: Respite Care is defined as services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing care. Respite services are provided in a variety of settings and may be provided on an hourly or daily basis.

NOTE: Respite services will not be authorized in concurrence with Personal Care Services, Adult Companion Services or Adult Attendant Care Services under any circumstances.

"Hourly respite" can be provided up to eight (8) hours in a calendar day and in a variety of settings such as the recipient's home, or a licensed respite care facility.

"Daily respite" is more than eight (8) hours of respite provided in a calendar day. *Daily respite* can also be provided in a variety of settings such as the recipient's home, a group home or a licensed respite facility.

"Institutional respite" is respite services provided on a daily basis in a hospital, nursing facility (NF), or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Institutional respite may be provided in a SCDDSN Regional Center or a community based ICF/MR. which has been approved by the State and which is not a private residence.

Issues regarding payment of respite caregivers for overnight care should be addressed according to individual DSN Board/Respite Provider policy and should be included in the agreement between the DSN Board/Respite Provider and the Respite Caregiver.

Please note: Issues regarding "difficulty of care" rates will be addressed by the local DSN Board provider. If you feel that the respite provider needs to be paid beyond the current hourly/daily rate based on the difficulty of care needed for a particular consumer, the early interventionist/service coordinator along with their Supervisor may authorize a higher rate. This should be done in cooperation with the DSN Board's financial department. Due to capitation, an increase rate does not mean that the DSN board will receive more money. There should be enough funding in the individual's band payment to accommodate a higher rate of respite care. If there is not enough funding, the DSN Board financial representative will need to apply for a different band payment or outlier status. If you decide to increase the rate for a particular consumer, your Supervisor must send this notice in writing to Trina Smalley at SCDDSN CO so the rate may be adjusted on the Waiver Tracking System.

Providers: *Daily* and *hourly respite* can be provided in the recipient's home or place of residence or another residence selected by the consumer/ representative. This service is provided by people who are hired/contracted by the local DSN Board and meet all of the caregiver minimum qualifications. Daily or hourly respite can also be provided in a Community Training Home I or II (CTH I or II) licensed by the South Carolina Department of Disabilities and special Needs (SCDDSN), a respite care facility, or in a Community Residential Care Facility (CRCF) licensed by SC Department of Health and Environmental Control (SCDHEC).

If *institutional respite* is provided, it must be provided in a facility that is licensed and certified by SCDHEC as an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

The respite services provider must meet all provider qualifications and training requirements outlined in SCDDSN's "Waiver Funded Home Supports, Caregiver Certification" (August 1, 2001) or be a

DSN Board employee. Respite services cannot be provided by a recipient's primary caregiver as defined by the State of South Carolina. Family members/relatives of the customer may be paid to provide respite when the family member/relative is not legally responsible for the customer and he/she meets all provider qualifications. The following people **cannot** be paid for providing respite:

- A primary caregiver;
- The spouse of the consumer;
- A parent, step parent, foster parent or legal guardian of a minor consumer;
- A court appointed guardian of an adult consumer;
- Parent or step-parent of adult waiver recipient who resides in the same household as the consumer.

The following are examples of people who may be paid to provide respite if all other provider qualifications are met and he/she is not one of the consumers' primary caregivers:

- A parent of an adult customer who does not reside in the consumer's household;
- A non-legally responsible family member (sibling, grandparent, aunt, uncle, etc.).

For purposes of this policy, "Legally Responsible" means "Legal Guardian" which is defined by Black's Law Dictionary as "A person lawfully invested with the power, and charged with the duty, of taking care of the person and managing the property and rights of another person, who, for defect of age, understanding, or self-control, is considered incapable of administering his own affairs. One who legally has the care and management of the person, or the estate, or both, of a child during its minority."

For purposes of this policy "minor" is defined as "An infant or person who is under the age of legal competence, which in South Carolina is age 18."

The previous (July 1, 1998) South Carolina Medicaid Waiver policy prohibited payment to any non-legally responsible family member living in the same household as the Medicaid recipient. This new policy allows payment to non-legally responsible family members (brother, sister, step parent, grandparent etc.) living in the same household as the Medicaid recipient.

Family members/relatives wishing to receive payment for respite services rendered must acknowledge that they are not a primary caregiver of the consumer and that they are not legally responsible for the consumer. **The Statement of Legal Responsibility for Respite Services (MR/RD Form 31)** form must be used to document this and must be completed prior to authorization of services. This information should be placed in the consumer's file.

If a relative/family member is unsure about whether or not he/she is the legally responsible guardian of the Medicaid consumer, please consider and discuss with them the following indicators. Please remember that you do not need to reach a decision on your own. If, after considering the indicators noted, there are questions regarding legal responsibility, please forward pertinent information and questions to your designated MR/RD Waiver Coordinator at SCDDSN Central Office and a legal opinion will be sought.

Is the person a minor (under age 18)?
If so, the minor must have a legally responsible guardian/be in someone's custody. For most minors, the parents are the legal guardian. For parents not to be the legal guardian, some legal/court action has to have occurred. If no legal/court action has occurred, the parents are the legal guardians.

- If the relative is not the minor's parent, has anyone gone to court to get custody of this child?
- Are there legal documents/court papers stating who has custody of the minor?

Is the person an adult (18 years of age or older)?
If so, people over the age of 18 are assumed to be competent and therefore may not have a legally responsible guardian. Parents are not automatically the legally responsible guardian of an adult with a disability. In order for anyone to be the legally responsible guardian of an adult, some sort of legal/court action has to have occurred.

- Are there legal documents/court papers stating that the person is not competent and appointing a guardian?
- If the documents exist, do they indicate the action to be a general adjudication or is the adjudication limited?
- If limited, is the adjudication limited to health care decisions? *If so the person is considered to be the legally responsible guardian and therefore cannot be paid for services.*
- If limited, is the adjudication limited to financial decisions/conservator appointed? *If so, the person may not be legally responsible; please forward to SCDDSN Waiver staff for opinion.*

If there are any doubts/questions regarding legal responsibility, submit in writing a description of the concern/situation and any other pertinent information, including copies of legal/court documents, to your designated MR/RD Coordinator at SCDDSN Central Office.

Determining the amount of respite needed: Respite is a unique service. It can be provided in a variety of settings, in a variety of ways. Often Respite is used in response to a family emergency or crisis. For many consumers it is used on a regular basis to provide relief to caregivers. For consumers whom respite is identified as an ongoing service that will be needed on a regular basis, completion of the **MR/RD Waiver Respite Assessment (MR/RD Form 35)** is required and should be forwarded to the MR/RD Waiver Coordinator when a budget request is made. The **MR/RD Waiver Respite Assessment (MR/RD Form 35)** is designed to provide the Service Coordinator/Early Interventionist with detailed information regarding the consumer's difficulty of care, the caregiver's stress level, and other information related to the need for respite. The information gathered from the assessment will help the Service Coordinator /Early Interventionist to determine the amount of respite appropriate to meet the needs of the consumer and their caregiver. This assessment is NOT designed to produce an amount of respite based on a score. The information included in **the MR/RD Waiver Respite Assessment (MR/RD Form 35)** will assist in supporting the amount of respite requested/provided.

Completion of this assessment is not required for consumers already receiving respite services. However, if additional units of service are requested exceeding 25 hours per week or 6 days per month, the **MR/RD Waiver Respite Assessment (MR/RD Form 35)** must be completed and forwarded to the MR/RD Waiver Coordinator when completing the budget request. Furthermore, completion of this assessment is not required for one-time/occasional requests or for respite uses in response to emergency situations.

Instructions regarding completion of the **MR/RD Waiver Respite Assessment (MR/RD Form 35)** are included on the form. There is no requirement that the assessment be completed with the consumer/family. You may already have the information necessary to complete the assessment, but in most circumstances you will have to follow-up with the consumer/family for some of the information.

Section II of the assessment is to be completed by the caregiver. This portion of the assessment should be given to the caregiver to complete, either by mail, fax, e-mail or in-person. You should not attempt to complete this section with the caregiver. Use this scale when scoring Section II only: Never = 0, Sometimes = 2, Always = 4. The total scores will produce the following categories: 0 - 14 = Mild/No Stress; 15 - 22 = Moderate Stress; and 22 - 36 = Severe Stress.

Arranging for hourly and daily respite: Once it is determined that respite services are needed, the need for the service, the amount needed and the frequency with which the service is to be provided must be clearly documented in the plan.

For *hourly respite*, one unit equals one hour. For *daily respite*, one unit equals more than eight (8) hours in a calendar day. When the frequency has been determined, the budget information can be entered in the Waiver Tracking System (S35-Daily; S46-Hourly; S13 Institutional).

Each consumer must be given a choice of providers of this service and **the offering of choice must be documented.**

Once approved Respite can be authorized using the **Authorization for Services MR/RD Form A-25** when the following kinds of respite services are chosen:

- daily or hourly respite provided in the consumer's home,
- daily or hourly respite provided in a licensed respite care facility, or
- daily respite provided in a group home (CRCF) operated by your agency
- daily or hourly respite provided in a nursing home.

Arranging for institutional respite: Once it is determined that institutional respite services are needed or the consumer is placed in an ICF/MR, nursing facility, or hospital due to an emergency/crisis, the need for the service, the amount needed and the frequency with which the service is to be provided must be clearly documented in the plan. **Please note that while a consumer is receiving institutional respite, they may continue to utilize other MR/RD Waiver services (e.g. Assistive Technology or Prescribed Drugs). The only service that cannot continue is residential habilitation. The Service Coordinator/Early Interventionist continues to be the authorizer of all services.**

For *institutional respite*, one unit equals one day when the consumer is present in the facility at midnight. When the frequency has been determined, the budget information can be entered in the Waiver Tracking System (S13 Institutional).

Each consumer must be given a choice of providers of this service and **the offering of choice must be documented.** In the case of an emergency or crisis situation, choice may not be an option. Simply document this in the consumer's file.

Once approved *institutional respite* can be authorized using the **Authorization for Services MR/RD Form A-32 (the Services Menu on the STS must also be updated to reflect *institutional respite* as a service that is being received)**. On the authorization indicate where the *institutional respite* will be provided, Center Based Respite (Coastal Center, Midlands Center, Pee Dee Center, Saleeby Center, or Whitten Center) or Community Based ICF/MR (noting the name of the facility), Nursing Facility Based, or Hospital Based.

- If the *institutional respite* is to be provided in a SCDDSN Regional Center (Center-Based), the authorization form should be directed to the appropriate Claims and Collections Officer (See

Attachment 1 for a list of Claims and Collections Officers). Included with the authorization should be a copy of the consumer's Medicaid Card and any other private insurance information.

- If the consumer is going to receive *institutional respite* in a community-based ICF/MR, the authorization form should be directed to the board/provider's finance director who operates the community ICF/MR where the consumer will receive respite.

For consumers receiving institutional respite at a Regional Center, the Admissions Packet must be submitted to the appropriate Placement Coordinator at the Regional Center (See Attachment 2 for a list of Placement Coordinators). For those receiving institutional respite at a Community ICF/MR, the Admissions Packet must be forwarded to the Board/Provider Residential Director. The admissions packet must include:

- Medication Administration Schedule
- Psychological Evaluation
- Behavior Support Information (if applicable)
- Single Plan
- Nutritional Information
- Physical (completed 30 days prior to respite)
- TB Test (2 step)
- Social History

The consumer should bring, at the minimum, the following items when reporting to an ICF/MR, nursing home, or hospital for respite:

- Medications in their original containers
- Spending money
- Medicaid Card
- Clothing
- Toiletries
- Durable Medical Equipment and Supplies (diapers, wipes, etc.)

In cases of an emergency/crisis, some of this information may not be present initially, but should still be obtained and forwarded to the Regional Center Placement Coordinator or the Board/Provider Residential Director.

In order for SCDDSN Central Office to bill for institutional respite, the Service Coordinator must on a monthly basis complete the Individual Service Report (ISR). This form is included for your use. This form should be completed and forwarded to SCDDSN Central Office to the attention of SURB. This must be done no later than the 15th of the proceeding month.

While the consumer receives *institutional respite* services, the Service Coordinator is required to monitor the consumer's services and progress at the minimum of every two weeks. **If the consumer is receiving *institutional respite* in a SCDDSN Regional Center,** a staffing must be held within 15-30 days of beginning *institutional respite* services. The SCDDSN Regional Center Staff will coordinate this meeting. The Service Coordinator, District Office SCDDSN Staff (if applicable), responsible party/family (if applicable), and Regional Center Staff must be present at the staffing. Discussions will be held in regards to the consumer's progress and a decision will be made as to whether or not the

consumer will continue to receive *institutional respite* (these steps and the staffing are not necessary for someone receiving institutional respite in a community ICF/MR, nursing facility or hospital).

If the team recommends that the consumer be admitted to the Regional Center, the following steps must be completed:

- For consumers that reside at home with family (not in a community residential setting), the Service Coordinator must initiate the process for approval of Critical Circumstance (Please refer to SCDDSN Directive 502-05-DD for procedures and forms).

If more restrictive placement/critical circumstance for placement in an ICF/MR is approved, the following steps should be completed.

- The Service Coordinator will notify the Placement Coordinator that the placement has been approved.

- Regional Center staff will complete an ICF/MR Level of Care if the consumer has **ever** been admitted to an ICF/MR. If the consumer is a new admission, the ICF/MR Level of Care will be completed by the Consumer Assessment Team. The Regional Center Staff will be responsible for submitting this packet to the Consumer Assessment Team

- Upon notification that the consumer has met ICF/MR Level of Care, the Claims and Collections Officer will notify the Service Coordinator and the appropriate Regional MR/RD Waiver Coordinator that the consumer is ready to be admitted to the Regional Center.

- The Service Coordinator will immediately take steps to ensure that the **Notice of Disenrollment (MR/RD Form 17)** is completed within two (2) working days and a **Notice of Termination of Service (MR/RD Form 16-B)** will be forwarded to the Claims and Collections Officer to terminate institutional respite services. The Service Coordinator will remove Institutional Respite as a service being received from the services menu on the STS so that ISR reports are no longer generated.

- The Claims and Collections Officer/Person Completing DHHS Form 181 will check the Waiver Tracking System to ensure that the consumer has been disenrolled from the MR/RD Waiver before proceeding with admitting the consumer to the ICF/MR and completing the DHHS Form 181 Form. A copy of the DHHS Form 181 form will be forwarded to the Waiver Enrollments Coordinator. If the Claims and Collections Officer notes that the consumer continues to remain enrolled in the MR/RD Waiver, they will notify the appropriate Regional MR/RD Waiver Coordinator.

If the team recommends that the consumer continue to receive SCDDSN Regional Center *institutional respite*, the following steps must be taken:

- Another staffing must be held within 15-30 days of the initial staffing. The SCDDSN Regional Center Staff will coordinate this second meeting. The Service Coordinator, District Office SCDDSN Staff (if applicable), responsible party/family (if applicable), and Regional Center Staff **must** be present at the staffing. Discussions will be held again in regards to the consumer's progress and a decision will be made as to whether or not the consumer will continue to receive *institutional respite* or if the team recommends admission to an ICF/MR.

- If the outcome of the meeting indicates that the consumer will continue to receive *institutional respite*, the Service Coordinator is responsible for notifying the Lead Coordinator for MR/RD Waiver and Services Planning at SCDDSN Central Office of this decision. This may be done via e-mail. If there are any issues or concerns, the Service Coordinator will be notified. A new **Authorization for Services (MR/RD Form A-32)** must be completed and forwarded to the Claims and Collections Officer and SCDDSN Central Office attention SURB Respite Care Authorizations.

- If the team recommends that the consumer be admitted to an ICF/MR, the procedures outlined above must be followed.

Given the circumstances surrounding the need for institutional respite, multiple staffings may be held with the outcome being that institutional respite services continue for an extended period of time. The above steps must be followed and a staffing must be held at least each month. SCDDSN Central Office must be notified as outlined above.

Please note: Although a staffing must be held at the minimum of every 15-30 days, up to 45 units of institutional respite can be and should be authorized. This will allow for any lapse that may occur. If the Regional Center does not have an authorization form they cannot bill for this service. If a consumer is admitted during a crisis on the weekend or in the evening, service may be authorized verbally and the **Authorization for Services (MR/RD Form A-32)** completed on the next business day. The form should be completed by the person that gave verbal approval for institutional respite. In this case they may authorize that the service began on the date that verbal approval was given and they may sign the form on the same date. This authorization should come from the Service Coordinator, Service Coordination Supervisor, Upper DSN Board management, or the Executive Director. All of this should be carefully documented in the consumer's file to include the verbal authorization.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the consumer's/family's satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following criteria should be followed when monitoring Respite Services.

Respite (hourly or daily)
- At least monthly for the two months
- At least quarterly thereafter

Respite (institutional)
- Every two weeks for the first month
- At least monthly thereafter

This service may be monitored during a contact with the individual/family or service provider. It may also be monitored during a review of notes completed during a respite stay. Monitorship of the individual's health status should always be completed as a part of respite monitorship. Some items to consider during monitorship include:

→ Is the individual receiving respite care as authorized?
→ Is the individual satisfied with the current respite provider?
→ Does he/she show up on time and stay the scheduled amount of time?
→ Does the provider show the individual courtesy and respect?
→ Does the caregiver feel that he/she is receiving enough relief from providing for the individual's care?

- → Does the service need to be continued at the current rate?
- → Is there need for additional respite to be requested at this time?
- → Are they pleased with the care being provided by the respite caregiver or is assistance needed in obtaining a new caregiver?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

South Carolina Department of Disabilities and Special Needs Regional Center Claims and Collections Officers

Midlands Center
Paul Justus
Midlands Center
8301 Farrow Road
Columbia, SC 29203-3294
(803) 935-7364
fax: (803) 935-6177
pjustus@ddsn.sc.gov

Whitten Center
Allen Longshore
Whitten Center
P.O. Box 239
Clinton, SC 29325
(864) 938-3165
fax: (864) 938-3115
alongshore@ddsn.sc.gov

Coastal Center
Jean Hamilton
Coastal Center
9995 Jamison Road
Summerville, SC 29485
(843) 821-5810
fax: (843) 821-5889
jhamilton@ddsn.sc.gov

Pee Dee and Saleeby Center
Deborah Reddick
Pee Dee Center
714 National Cemetery Road
Florence, SC 29502-3209
(843) 664-2613
fax: (843) 664-2692
dreddick@ddsn.sc.gov

South Carolina Department of Disabilities and Special Needs Regional Center Placement Coordinators

Midlands Center
Nancy Hall
Midlands Center
8301 Farrow Road
Columbia, SC 29203-3294
(803) 935-6037
fax: (803) 935-7678
nhall@ddsn.sc.gov

Whitten Center
Len Humphries
Whitten Center
P.O. Box 239
Clinton, SC 29325
(864) 938-3396
fax: (864) 938-3115
lhumphries@ddsn.sc.gov

Coastal Center
Rebecca D. Hill
Coastal Center
9995 Jamison Road
Summerville, SC 29485
(843) 821-5854
fax: (843) 821-5800
bhill@ddsn.sc.gov

Pee Dee and Saleeby Center
Don Lloyd
Pee Dee Center
P.O. Box 3029
Florence, SC 29501
(843) 664-2635
fax: (843) 664-2692
dolloyd@ddsn.sc.gov

South Carolina Department of Disabilities and Special Needs

Statement of Legal Responsibility for Respite Services

Consumer's Name: _____

SSN: _____

Date of Birth: _____

Respite services are defined as care provided to the SCDDSN consumer in the absence of the caregiver or when the caregiver needs relief from the responsibilities of care giving. A consumer's primary caregiver(s) cannot provide respite. The primary caregiver(s) of the consumer noted above is/are:

_____

_____

South Carolina Medicaid Policy prohibits anyone who is legally responsible for the health care decisions of another to be paid for rendering respite services to that person. If you are legally responsible for the health care decisions of the consumer noted above you can not be paid for providing respite services.

By signing this statement you acknowledge that:

- you are <u>not</u> a primary caregiver of the consumer noted above, AND
- you are <u>not</u> legally responsible for his/her health care decisions.

I am not a primary caregiver of the person noted above and I am not legally responsible for the person noted above.

_____ _____

Signature Date

_____

Printed Name

MR/RD Form 31(09/05)

South Carolina Department of Disabilities and Special Needs
Mental Retardation/Related Disabilities Waiver
Respite Assessment

Consumer's Name:_____ SSN#:_____ Age:_____

DSN Board/Provider:_____ SC/EI:_____

Consumer's Primary Caregiver(s):

Name:_____ Relationship:_____ Age:_____
Name:_____ Relationship:_____ Age:_____
Name:_____ Relationship:_____ Age:_____

Consumer's Primary Diagnosis (check only one):

☐ MR
☐ RD-Autism
☐ RD-Other_____
☐ Other_____

Additional Diagnosed Conditions (check all that apply)

☐ Blindness
☐ Cerebral Palsy
☐ Brain or neurological damage
☐ Chronic brain syndrome
☐ Chemical dependence
☐ Deafness
☐ Epilepsy or seizures
☐ Mental illness: psychosis, schizophrenia, etc.
☐ Situational mental health problems
☐ Other_____

Is this consumer on the SCDDSN Critical Circumstance list? ☐ Yes ☐ No

Part I. Skills Assessment/Difficulty of Care

Directions: check the answer that best describes the consumer and place the score in the space indicated.

1. Toileting Skills:	**Adult**	**Child 0-4**	**Child 5-17**	**Score**
a. Is toileted trained	0☐	0☐	0☐	
b. Partially toilet trained/requires prompting	5☐	0☐	4☐	
c. Not toilet trained/requires full assistance	8☐	1☐	6☐	
d. Inappropriate toileting skills	8☐	3☐	8☐	

Comments:_____

2. Bathing Skills:	**Adult**	**Child 0-4**	**Child 5-17**
a. Bathes self without assistance	0☐	0☐	0☐
b. Requires minimal assistance/prompting with bathing	3☐	0☐	2☐
c. Requires maximum assistance with bathing	5☐	2☐	5☐

Comments:_____

3. Grooming/Hygiene Skills:	**Adult**	**Child 0-6**	**Child 7-17**
a. Independently maintains personal appearance/hygiene	0☐	0☐	0☐
b. Requires minimal assistance/prompting in maintaining personal appearance and hygiene	3☐	0☐	2☐
c. Requires maximum assistance in maintaining personal appearance and hygiene	5☐	1☐	5☐

Comments:_____

4. Eating Skills:

		Adult	Child 0-4	Child 5-17
a.	Feeds self without assistance	0☐	0☐	0☐
b.	Requires minimal assistance/prompting with eating	3☐	0☐	2☐
c.	Must be fed	6☐	1☐	6☐
d.	Tube Feed	8☐	8☐	8☐

Comments:_____

5. Mobility Skills (in the home):

		Over 50 lbs.	Under 49 lbs.
a.	Walks independently or uses device for independent mobility	0☐	0☐
b.	Requires minimal assistance	2☐	2☐
c.	Needs constant supervision to ambulate safely	6☐	3☐
d.	Is not mobile/requires physical assistance with all tasks	8☐	8☐

Comments:_____

6. Mobility Skills (in the community)

		Over 50 lbs.	Under 49 lbs.
a.	Walks independently or uses device for independent mobility	0☐	0☐
b.	Requires minimal assistance	2☐	2☐
c.	Needs constant supervision (e.g. eloping/wandering)	6☐	3☐
d.	Is not mobile/requires physical assistance with all tasks	8☐	8☐

Comments:_____

7. Vision:

a.	No visual problem/minor problem corrected with lenses	0☐
b.	Some visual impairment	2☐
c.	Legally blind	4☐
d.	Blind	6☐

Comments:_____

8. Receptive Communication:

a.	No problem hearing or understanding spoken language	0☐
b.	Partial hearing loss (uncorrected); limited understanding of spoken language. Responds to gestures rather than speech; has trouble processing speech	2☐
c.	Deaf/little or no understanding of spoken language or gestures/delayed auditory processing	7☐

Comments:_____

9. Expressive Communication:

a.	Uses speech	0☐
b.	Primarily uses gestures, sign language, communication board, etc.	2☐
c.	Little or no expressive communication/cannot express wants and needs	6☐
d.	Echolalia (communicative/delayed)	7☐

Comments:_____

10. Behavior:

a. No significant behavior problems 0☐
b. Has frequent, but manageable behavior problems 5☐
c. Has frequent, aggressive and/or dangerous behavior problems 11☐

Comments:_____

11. Seizures:

a. No seizures, or seizures completely controlled by medication 0☐
b. Occasional seizures, averaging about one per week or less 2☐
c. Frequent seizures, averaging more than one per week 5☐

Comments:_____

12. Medication:

	Adult	Child 0-12	Child 13-17
a. Takes no medication or is responsible for taking own medication without need for assistance	0☐	0☐	0☐
b. Takes own medication, but requires assistance in doing so	1☐	0☐	1☐
c. Medication must be administered for the consumer	3☐	0☐	3☐

Comments:_____

13. Prompting and Cuing:

	Adult	Child 0-8	Child 9-17
a. Requires no cuing, prompting and/or redirection in an average day	0☐	0☐	0☐
b. Requires occasional cuing, prompting or redirection throughout the day	2☐	0☐	2☐
c. Requires constant cuing/prompting or redirecting throughout the day	6☐	1☐	6☐

Comments:_____

14. Medical Status: Individual has medical condition requiring specialized care—check all that apply:

a. frequent suctioning ☐ 7
b. ventilator dependent ☐ 8
c. feeding tube ☐ 6
d. wound care ☐ 5
e. catheter care/change ☐ 5
f. Chest Physical Therapy (CPT) ☐ 8
g. range of motion exercises ☐ 4
h. trach care ☐ 8
i. repositioning ☐ 3
j. diabetes care ☐ 5
k. not applicable ☐ 0

Comments:_____

15. Physical Health: Requires care by a nurse or physician:

a. Less than monthly 1☐

b.	Monthly	2☐
c.	Weekly	3☐
d.	Daily	4☐

Comments:_____

16.	**Supervision**	**Adult**	**Child 0-8**	**Child 9-17**
a.	Requires occasional/little support during the day (outside of visual supervision for 1-3 hour periods	2☐	1☐	2☐
b.	Requires limited support and supervision (within the same room or nearby, outside of visual supervision for 1 hour periods)	4☐	2☐	3☐
c.	Requires extensive, moderate intense levels of support and supervision (within the same room or nearby, outside of visual supervision for 15 minute periods)	6☐	6☐	6☐
d.	Requires pervasive, continuous, highly intense levels of support and supervision (direct, continuous visual contact)	10☐	10☐	10☐

Comments:_____

TOTAL SCORE _____

The total scores will produce the following categories:

- 0 – 10 = Age Appropriate Amount of Care Required
- 11 – 30 = Mild Difficulty of Care Required
- 31 – 40 = Moderate Difficulty of Care Required
- 41 – 80+ = High/Severe Difficulty of Care Required

Part II: Caregiver Stress Interview Assessment:

Instructions: Please provide this section of the assessment to the parent/caregiver/guardian for them to complete and return to you. This may be completed over the phone, during a home visit, or by mailing it to the caregiver. This section is designed to determine the amount of stress the parent/caregiver/guardian is experiencing.

Caregiver: The information requested below may seem personal, but we want to understand the stress you may be experiencing in order to provide you with relief. The following is a list of statements which reflect how people may feel when taking care of another person. After each statement, indicate how often you feel this way: never, sometimes, or always. There are no right or wrong answers.

QUESTION	Never	Sometimes	Always
1. How often do you feel that you don't have enough time for yourself?			
2. How often do you feel stressed and overwhelmed between caring for yourself and your family and trying to meet other responsibilities?			
3. Are you afraid of what the future holds for your relative if something were to happen to you or your family?			
4. Do you feel you do not or will not have enough money to care for your consumer?			
5. Do you feel your health has suffered because of the care you provide to your family?			
6. Do you feel you don't have as much privacy as you would like because of your relative?			
7. Do you feel you will be unable to take care of your relative much longer?			
8. Do your responsibilities for yourself and your family make you feel out of control?			
9. Do you feel that you do not have enough time for each member of your family?			

TOTAL SCORE:_____ (See Respite Service Chapter for Instructions)

Part III: Request for Respite and General Information

1. Does the primary caregiver have any health/medical/mental health issues? ☐ Yes ☐ No If yes, explain.

_____

_____

_____

2. If respite is needed to enable the primary caregiver to work/attend school, indicate what other resources have been explored to meet this need and the primary caregiver's work/school schedule:

_____

_____

3. Is the primary caregiver responsible for providing care to other individuals? (e.g. elderly parent, other children, another disabled consumer, etc.)? ☐ Yes ☐ No If yes, whom?

_____

_____

4. What is the household composition:
   Number of Adults: Age(s):
   Number of Children: Age(s):

5. Are there other caregivers in the home that provide assistance in caring for the consumer such as a spouse, grandparent, etc. ? ☐ Yes ☐ No If yes, whom?

_____

_____

   Are there friends, neighbors, church members, and/or extended family members being used to assist in caring for the consumer? ☐ Yes ☐ No If yes, whom?

_____

_____

6. Are there opportunities for spouses/caregivers to spend time together, without having to provide direct care for this consumer? ☐ Yes ☐ No If yes, how often and who assists?

_____

_____

7. Are there any needs that the consumer has on his plan that are not being met? If so, please list.

_____

_____

8. What services is the consumer currently receiving?

☐ Personal Care Services: _____ (amount/frequency)
☐ Family Support funds for_____
☐ Attends Public School
☐ Adult Day Health Care
☐ Behavior Support/Psychological Services
☐ Day Care
☐ Applied Behavior Analysis (ABA Therapy)
☐ Summer Camp
☐ Nursing:_____ (amount/frequency)
☐ OT/PT/Speech
☐ Assistive Technology
☐ Companion Services
☐ Prevocational/Day Services
☐ Consumer is homebound
☐ EI Services

9. If skilled tasks are required during respite for this consumer (e.g. medication administration, tube feedings, suctioning, etc.), what is the plan for these tasks to be completed by a qualified family member or Nurse? Please describe.

_____

_____

_____

_____

10. Is the primary caregiver being paid to provide Personal Care services to the consumer? ☐ Yes ☐ No

11. How much time every day/week is the caregiver responsible for caring for their consumer with the exception of sleep time?

_____

_____

_____

_____

12. Does the caregiver experience sleepless nights or is the caregiver unable to sleep consistently due to the care of their consumer? ☐ Yes ☐ No If yes, explain.

_____

_____

13. Has there been a change of circumstances in the consumer's home that has added additional stressors (e.g. death of parent, death of spouse, divorce, relocation, etc.)? ☐ Yes ☐ No If yes, explain.

_____

_____

14. Has the caregiver experienced any loss of income due to caring for their consumer? ☐ Yes ☐ No

15. Has the caregiver had to quit his/her job or reduce his/her hours in order to care for their consumer?
☐ Yes ☐ No

16. Please indicate below your recommendation and specific justification for the amount of respite service services that you are recommending.

17. Other comments related to the request for respite services.

Signature of Person Completing Assessment

Title

Printed Name of Person Completing Assessment

Date

Review by Supervisor

Date

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE *BILLED TO DSN BOARD*

TO: _____

_____

RE: _____
Consumer's Name / **Date of Birth**

_____
Address

Medicaid # /___/___/___/___/___/___/___/___/___/___/___/

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Respite Care Services:

Hourly Respite
Number of Units Per _____ : _____
(one unit = 1 hour of service)

Daily Respite
Number of Units Per _____ : _____
(one unit = 1 respite period of more than 8 consecutive hours)

REMIT BILL TO (Please print):

_____

_____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-25 (revised 06/06)

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR ICF/MR (INSTITUTIONAL) RESPITE SERVICES
TO BE *BILLED TO DSN BOARD*

☐ **Center-Based Respite**
- ☐ Coastal Center
- ☐ Midlands Center
- ☐ Pee Dee Center
- ☐ Saleeby Center
- ☐ Whitten Center

* ☐ **Community ICF/MR**
* ☐ **Nursing Facility**
* ☐ **Hospital**

_____
* Indicate Name of facility

TO: _____
For Center Based: Claims and Collections (see attachment)
For Community ICF/MR: Board/Provider Finance Director

_____
Address

RE: _____
Consumer's Name / **Date of Birth**

Medicaid # / / / / / / / / / / /

Social Security # / / / / / / / / / / /

You are hereby authorized to provide institutional respite to the consumer named above. The consumer cannot be admitted to the ICF/MR (DHHS 181 completed) without first notifying the Service Coordinator (noted below) and verifying that the consumer has been disenrolled from the MR/RD Waiver. Please note: This nullifies any previous authorization to this provider for this service.

Institutional Respite

☐ Number of Units _____ (one unit = number of nights spent in the ICF/MR/facility)
Start Date: _____

Service Coordinator/Early Interventionist _____

Board/Provider: _____

Address: _____

Phone Number (with extension when appropriate): _____

_____ _____
Signature of Person Authorizing Services Date

MR/RD Form A-32 (revised 11/08)

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
Home and Community Based Waiver
Respite Care – Regular
Individual Service Report

For: _____ (month and year)

Region: _____ Provider Name: _____
Paid Number: _____ Provider No : _____

Individual SSN: _____-_____-_____ Individual Name: _____
Medicaid #: _____

Service Coordinator's Name: _____

Service Coordinator's Signature: _____

Type Of Service: Respite Care (_____)
Each service reported must be documented in Individual's File

Non-Facility Based				**Facility Based**	
Daily and Hourly Respite *(Fill in the date of service, the beginning and ending time for all non-facility based respite)*				**Daily Respite** *(Fill in the date of service)*	
Date of Service	**Beginning Time (Hours/Minutes)**	**Ending Time (Hours/Minutes)**	**DDSN Use**	**Date of Service**	**DDSN Use**
/ /	:	:		/ /	
/ /	:	:		/ /	
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Comments _____				Comments: _____	

Attn: Comments are required if no activity is rendered.

SC Department of Disabilities & Special Needs
Home Supports
Caregiver Certification

Effective October 1, 2001

The following guidelines apply to the MR/RD Waiver, PDD Waiver and HASCI Waiver funded home supports that are provided by DSN Boards. These guidelines supersede portions of DDSN Administrative Agency Standard relating to Staff Development and Training (136), and all other policies, directives, or guidelines regarding the provision of designated services through a DDSN Home and Community Based Waiver. All payments must be made directly to the provider of the service (caregiver) and cannot be made to the family or the consumer. Payments will not be made for services rendered by relatives of the consumer as defined by South Carolina Medicaid Home and Community Based Waiver policy. Services covered in these guidelines are:

MR/RD Waiver:	**Respite, Companion, Homemaker, Personal Assistance/Attendant Care**
HASCI Waiver:	**Respite, Personal Assistance/Attendant Care**
CS Waiver:	**Respite, In-Home Support**
PDD Waiver:	**Respite, Companion, and Homemaker**

Minimum qualifications for caregivers:

- The caregiver will have the ability to read, write and speak English.
- The caregiver will be at least 18 years of age.
- The caregiver will be capable of aiding in the activities of daily living (not required for Rehabilitation Supports caregiver if not part of the job for which he/she is hired).
- The caregiver will be capable of following a plan of service with minimal supervision.
- The caregiver will have no record of abuse, neglect, crimes committed against other people or felonious convictions of any kind.
- The caregiver will be free from communicable and contagious diseases.
- The caregiver will have a valid Driver's License (if driving is required as part of the job). The DSN Board will perform an initial inspection of the official Highway Department's driving record for each caregiver who will be transporting individuals.
- The caregiver will document hours worked and the nature of the tasks performed. The waiver consumer or his/her designee (i.e., parent, sibling, etc.) will verify the documentation.
- If providing Personal Assistance/Attendant Care supervision will be provided by a RN or as otherwise allowed within the provision of state law.
- The caregiver will demonstrate competency in required training. (See attached training requirements for caregivers.) Training will include the attached minimum guidelines for training as well as any special techniques/procedures/equipment required to adequately provide services for the individual prior to assuming responsibility.
- If respite is provided outside of the Waiver consumer's home, the location of the respite must be licensed according to "Standards for Respite and Short Term Service" (July 1994) or other applicable standards.

Training Requirements for Caregivers

All caregivers must have the skills and abilities to provide quality services for the people they serve. Minimally, caregivers must demonstrate competency in the following areas (taken directly from the CORE pre-service curriculum) before services are provided. *Hours in parentheses are estimates of the time needed to achieve competency and may be higher or lower depending on the existing skill level of the caregiver and the skills required for serving a particular waiver consumer.*

1. Confidentiality, Accountability and Prevention of Abuse and Neglect (1.5 hours)
2. First Aid (4 hours)
3. Fire Safety/Disaster Preparedness related to the specific location of services (1hour)
4. Understanding Disabilities (MR/RDs, MR/RD and Autism **OR** Orientation to Head and Spinal Cord Injuries (HASCI) : This training must be specifically related to the person/family needing services (1-3 hours)
5. Signs and Symptoms of Illness and Seizures (1 hour)

The following describes two ways in which caregivers can demonstrate competency:

1. Taking and passing tests (CORE curriculum) in the above categories. Tests may be taken as part of DSN Board Training or may be taken when training does not occur.

2. Consumer/responsible party can approve caregiver competency for items 3 - 5 above, but cannot sign off on items 1 or 2.

Caregivers must also demonstrate competency in any consumer-specific special techniques/procedures/equipment and must be oriented to the habits, preferences, and interests of the consumer. The consumer or family will typically provide this training to the caregiver. DSN providers, however, should allow access, upon request, to training classes and/or assist with caregiver training. Caregivers must be able to communicate with the consumer.

The consumer/responsible party, prior to services beginning, must complete the attached Caregiver Certification form for each caregiver. This form along with supporting documentation (training records, tests, etc.) will be maintained by the local DSN Board.

HOME SUPPORTS
CAREGIVER CERTIFICATION

Caregiver Information:

Name: _____

Social Security Number: _____

Address: _____

_____

Phone Number: _____

The above named caregiver has demonstrated competency in the areas noted below through the successful completion of training or by exemption from the training as approved by me.

Name of Training	Training/Date	Exemption/Date
Confidentiality, Accountability & Prevention of Abuse and Neglect		**XXXXXXXXXXXXXX**
First Aid		**XXXXXXXXXXXXXX**
Fire Safety/Disaster Preparedness		
Understanding Disabilities (MR/RDs, MR/RD or Autism) OR Orientation to Head and Spinal Cord Injuries		
Signs and Symptoms of Illness & Seizures		

The above named caregiver has been oriented to the habits, preferences and interests of _____ and is competent to perform the tasks needed to provide his/her care.

_____ _____

Consumer/Responsible Party **Date**

_____

Relationship of Responsible Party to Consumer